MEDI-CAL UPDATE Part 2
Billing and Policy
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Outpatient Services • Rehabilitation Clinics

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Contents

Xolair (Omalizumab) Injection Code Change and Dosage Correction

Effective April 1, 2006, providers must use HCPCS code J2357 when billing Xolair (omalizumab). Also, the *Injections* section of the Part 2 manual is updated to indicate the correct dosage for Xolair as 5 mg. *This information is reflected on manual replacement page inject 53 (Part 2).*

Enzyme Replacement Drugs Policy Update

Effective for dates of service on or after March 1, 2006, *Treatment Authorization Request* (TAR) requirements, billing codes and reimbursement rates for laronidase, alglucerase and agalsidase are updated to reflect the following:

Change From	Unit Dose	Change To	Unit Dose
Laronidase (C9209)	2.9 mg	Laronidase (J1931)	0.1 mg
Alglucerase (X7038)	80.0 u	Imiglucerase (J1785)	1.0 u
Alglucerase (J0205)	10.0 u		
Agalsidase (C9208)	1.0 mg	Agalsidase beta (J0180)	1.0 mg
Agalsidase (S0159)	35.0 mg		

Authorization requests for Medi-Cal recipients less than 21 years of age must be submitted to the California Children's Services (CCS) program. TARs for Medi-Cal recipients must be submitted to the Los Angeles Medi-Cal Medical (not Pharmacy) Field Office. Providers billing for recipients who are covered by both Medicare and Medi-Cal must bill Medicare first.

AUTHORIZATION REQUIREMENTS

The following specific clinical information is required when submitting a TAR for laronidase, imiglucerase or agalsidase beta:

Diagnosis and Age Requirements

When administering laronidase, a diagnosis of Mucopolysaccharidosis (ICD-9 diagnosis code 277.5) must be established. The recipient must be 5 years of age or older.

When administering imiglucerase, a diagnosis of Gaucher's disease (ICD-9 diagnosis code 272.7) must be established. There is no age requirement for the authorization of the use of imiglucerase.

When administering agalsidase beta, a diagnosis of Fabry's disease (ICD-9 diagnosis code 272.7) must be established. The recipient must be 16 years of age or older.

Please see **Enzyme Replacement**, *page 2*

Enzyme Replacement *(continued)*

Supporting Documentation
Supporting documentation for diagnosis and treatment of the established condition(s) must be submitted, including the following:

- Objective findings (exams, lab results)
  - Enzyme levels or other laboratory testing
  - DNA mutation analysis
  - Medical history
  - Physical examination
- Subjective findings (complaints, family history)
- Complications of disorder (for example, bony changes or kidney failure)
- Quality of life issues (for example, severe, unremitting pain or extreme fatigue)
- Identified caregiver (pediatric or internal medicine specialist) who can administer infusion therapy and coordinate care, and their:
  - Plan: Include the treatment plan and the genetic evaluation and counseling information for the recipient and family members
  - Goal: Include information about the desired outcome of the treatment plan; for example, to slow the progression of the disease, to allow regular attendance at work or school or to significantly improve the quality of life

Initial drug therapy will be approved as a three- or six-month trial, and a renewal TAR must include follow-up information. Follow-up documentation must note any significant changes in physical findings, laboratory parameters, symptoms and/or quality of life.

Special Instructions for Imiglucerase
Imiglucerase (HCPCS code J1785) is billed per unit, and dosage is based on the recipient's weight. Since the claim form cannot accommodate a four-digit number in the *Quantity* field, a separate authorization process is necessary.

The following are additional paper TAR instructions for imiglucerase:

- TAR submission and authorization requires the use of the negotiated rate process for reimbursement.
- Each administration of imiglucerase must be submitted on a separate TAR.
- The provider must document the patient's weight and the dosage of imiglucerase in the *Medical Justification* area of the TAR.
- In the *Specific Services Requested* area of the TAR, enter the number one (1) in the *Quantity* field.
- In the *Charges* field, enter the dollar amount of the usual and customary charge for the procedure.

Note: When submitting a claim for the reimbursement of imiglucerase, enter a one (1) in the *Service Units* column on the *UB-92 Claim Form*.

Please see **Enzyme Replacement**, *page 3*

Enzyme Replacement *(continued)*

The following are additional instructions for imiglucerase when submitting an eTAR:

- To submit an eTAR, access the "TAR Services" window and click "Non-Pharmacy Issue Drug."
- In the "Other Services" window, enter a quantity of one (1) in the "Total Units" field, then complete all other applicable fields as appropriate, including the "Charges" field (enter the usual and customary charge).
- Access the "Enter Miscellaneous TAR Information" window and enter the recipient's weight and dosage of imiglucerase to be given.

This updated information is reflected on manual replacement pages inject 23, 55 and 56 (Part 2) and inject list 2, 4 and 9 (Part 2).

VFC Reminder that FluMist is Billed with a New Code Starting April

The November 2005 *Medi-Cal Update* announced that the administration fee for FluMist (influenza virus vaccine, live, for intranasal use) is a new benefit for the Vaccines For Children (VFC) program. The article indicated that the code to use for billing FluMist would change in 2006. The following chart summarizes the two codes and corresponding dates of service to use for billing FluMist.

Dates of Service	Bill With	CPT-4 Description
On November 1, 2005 through March 31, 2006	CPT-4 code 90749 and modifiers -SK (members of high-risk population) and -SL (state-supplied vaccine)	Unlisted vaccine/toxoid
On or after April 1, 2006	CPT-4 code 90660 and modifiers -SK and -SL	Influenza virus vaccine, live, for intranasal use

Dispensing Guidelines
FluMist is reimbursable only for healthy individuals 5 through 18 years of age who are close contacts of people with chronic health conditions.

Documentation for Patient's Record
Providers must note in the patient's record that the vaccine was administered to a healthy individual who is in close contact with a chronically ill individual and the reason the provider chose an intranasal preparation over an injectable vaccine.

Code 90749 Reminder
Providers were instructed that when billing for code 90749, they must document in the *Remarks* area or on an attachment to the claim, that code 90749 was used to bill the VFC administrative fee for FluMist.

Special timeliness overrides have been established for claims submitted with code 90749 for dates of service on or after November 1, 2005 through March 31, 2006.

Code 90660 information is reflected on manual replacement pages modif used 4 (Part 2) and vaccine 3 and 4 (Part 2).

End Stage Renal Disease Pilot Project

Under a four-year pilot project, recipients with End Stage Renal Disease (ESRD) may enroll in "VillageHealth operated by SCAN Health Plan" (VillageHealth), a Medicare Health Maintenance Organization (HMO). Effective for dates of service on or after January 1, 2006, VillageHealth serves recipients in select ZIP codes in San Bernardino and Riverside counties. Ordinarily, recipients with ESRD would be excluded from enrollment in a Medicare HMO.

VillageHealth is partnering with DaVita and other providers in this endeavor, as follows:

- VillageHealth (an ESRD Specialty Health Plan/California Medical Services Demonstration Project) is the primary payer
- DaVita renders the dialysis services
- Other providers may render additional medical services

Provider Manual
Policy about this pilot project has been added to the *MCP: Special Projects* section of the Part 1 Medi-Cal provider manual.

Billing
Providers bill for services to VillageHealth members as follows:

- Plan-covered services to VillageHealth
- Copayments, coinsurance or deductibles for plan-covered services to Medi-Cal (similar to crossover claims)
- Services denied or not covered by VillageHealth, to Medi-Cal as standard fee-for-service claims

Copayments, Coinsurance and Deductibles
Claims for copayments, coinsurance or deductibles must be submitted as paper claims. Instructions for submitting paper claims closely parallel instructions for billing Medicare/Medi-Cal hard copy crossover claims, except for the few additional requirements noted below. Therefore, billers should refer to the "Hardcopy Submission Requirements of Medicare-Approved Services" in the Part 2 manual.

In their interpretation of the manual, billers should consider "VillageHealth" the same as "Medicare." For example, in the *Medicare/Medi-Cal Crossover Claims: Outpatient Services* section, under the "Part B Services Billed to Part B Carriers" heading, the reference to "Medicare approved service" would also be interpreted as "VillageHealth approved service."

In addition, claims for copayments, insurance or deductibles treated like crossovers must be billed to Medi-Cal with the same national procedure codes and modifiers billed to VillageHealth and include the following:

- A copy of the *Remittance Advice* (RA) received from VillageHealth. The RA must state "SCAN ESRD PILOT" in the *Remarks* section at the bottom left and include the address and telephone number for VillageHealth in the upper right corner. The RA provided by VillageHealth must be in the *Medicare National Standard Intermediary* (Medicare RA) format equivalent to the latest PC Print single claim detail version with billed amounts, paid amounts, group codes, reason codes, amounts showing line level coinsurance, and deductible amounts and other adjustments, as appropriate.
- VillageHealth AEVS (Automated Eligibility Verification System) carrier code "S323" in Box 56 on the *UB-92 Claim Form*.

Electronic billing may eventually be an option.

This information is reflected on manual replacement pages mcp spec 7 and 8 (Part 1) and medicare 3 (Part 1).

Instructions for Manual Replacement Pages — Part 2

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Remove and replace:	inject 23 thru 26
Remove:	inject 53/54
Insert:	inject 53 thru 57
Remove and replace:	inject list 1 thru 4, 9/10 modif used 3/4 vaccine 3/4